



COUNTY OF LOS ANGELES • OFFICE OF THE ASSESSOR
500 WEST TEMPLE STREET, ROOM 225 • LOS ANGELES, CA 90012-2770
Telephone: 213.974.3481 • Email: exempt@assessor.lacounty.gov • Website: assessor.lacounty.gov
Si desea ayuda en Español, llame al número 213.974.3211

**WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT,
REHABILITATION – LIVING QUARTERS (Yearly Filing)**

A separate affidavit must be filed for each location.

This affidavit is required under the provisions of sections 251 and 254.5 of the Revenue and Taxation Code for those organizations where the use of the property involves rehabilitation of persons and/or living quarters.

The affidavit must accompany the claim for welfare exemption and be filed with the Assessor, by February 15. If you do not complete and file this form, your exemption may be denied.

- _____ **states:**
(name of person making affidavit)
1. He/She is _____
(title, such as President, etc.)
2. of the _____,
(corporate or organization name)
3. the address of which is _____;
(give complete address including zip code)
4. for the property located at _____;
(give complete address including zip code)
5. that he or she makes this affidavit on behalf of this organization in support of a claim for exemption for the 20____ -20____
fiscal year.

CERTIFICATION

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing and all information hereon, including any accompanying statements or documents, is true, correct, and complete to the best of my knowledge and belief.

SIGNATURE OF PERSON MAKING AFFIDAVIT

TITLE

DATE





RICK AUERBACH
ASSESSOR

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REHABILITATION

A. On a separate sheet describe your rehabilitation program and activities in detail.

B. Thrift shop, workshop, manufacturing, or similar activities.

Number of hours per week the store or other facility is operated: _____

Total number of persons employed on the premises on January 1:

- | | |
|---|------------------------|
| 1. Persons being rehabilitated | 2. Staff and/or others |
| a. Full-time _____ | a. Full-time _____ |
| b. Part-time _____ | b. Part-time _____ |
| c. Length of employment of persons being rehabilitated: | |
| Number of persons, less than six months _____ | |
| Number of persons, 6 months - 1 year _____ | |
| Number of persons, 1 year - 2 years _____ | |
| Number of persons, longer than 2 years _____ | |
| (list by number of years) | |

C. Total number employed off the premises, but in the operations of the store or other facility as of January 1:

- | | |
|---|------------------------|
| 1. Persons being rehabilitated | 2. Staff and/or others |
| a. Full-time _____ | a. Full-time _____ |
| b. Part-time _____ | b. Part-time _____ |
| c. Length of employment of persons being rehabilitated: | |
| Number of persons, less than six months _____ | |
| Number of persons, 6 months - 1 year _____ | |
| Number of persons, 1 year - 2 years _____ | |
| Number of persons, longer than 2 years _____ | |
| (list by number of years) | |

D. Total number of hours worked during the time period included in the financial statements that accompany the claim:

- | | |
|-------------------------------------|-------------------------------------|
| 1. Persons being rehabilitated | 2. Staff and/or others |
| a. Number of hours worked _____ | a. Number of hours worked _____ |
| b. Number of persons involved _____ | b. Number of persons involved _____ |

E. Salaries and wages paid during the time period included in the financial statements that accompany the claim:

- | | |
|-------------------------------------|-------------------------------------|
| 1. Persons being rehabilitated | 2. Staff and/or others |
| a. Salaries and wages _____ | a. Salaries and wages _____ |
| b. Number of persons involved _____ | b. Number of persons involved _____ |

F. Does a person, management firm, or entity other than the organization filing this claim operate the store or facility? ☐ Yes ☐ No

If **yes**, please provide the operator's name and mailing address: _____

Amount of salary or fee (attach a copy of the contract or other document that indicates the basis for the salary or fee): \$ _____

G. Is housing for persons being rehabilitated and/or living quarters for staff provided? ☐ Yes ☐ No

If **yes**, explain the necessity and complete the section titled Housing — Living Quarters.

HOUSING — LIVING QUARTERS

(This section is to be completed if one or more persons lives on the premises.)

A. Total number of persons who were housed on the premises the last night in December (include persons who may be temporarily away):

1. Number of persons being rehabilitated _____
2. Number of unoccupied beds available for persons to be rehabilitated..... _____
3. Number of staff members necessary to care for those persons being rehabilitated (attach a list which describes the job performed and the number of persons involved) _____
4. Number of other staff members _____
5. Number of other persons who are not directly connected with the rehabilitation program _____

B. Length of stay of persons being rehabilitated who were housed on the premises the last night in December:

1. Number of persons
less than six months _____
6 months - 1 year _____
1 year - 2 years _____
2 years or longer (list by number of years) _____
2. Total (this figure **must** agree with the total given above for persons being rehabilitated): _____

C. Do persons being rehabilitated pay, donate, or perform fund producing work for their room and/or board? ☐ Yes ☐ No

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

D. Do staff members who care for those being rehabilitated pay, donate, or perform work for their room and/or board (in lieu of, or from their salary)? ☐ Yes ☐ No

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

E. Do other staff members pay, donate, or perform work for their room and/or board (in lieu of, or from their salary)? ☐ Yes ☐ No

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.

F. Do the other persons not directly connected with the rehabilitation program pay, donate, or perform work for their room and/or board? ☐ Yes ☐ No

If **yes**, indicate which and explain in sufficient detail to determine the monthly fee per person.
